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IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

ERICA JIMENEZ, individually and on behalf of a class of similarly situated individuals,

Plaintiff,

v.

DR. ERICA PAN, in her official capacity as Director of the California Department of Public Health; DR. BARBARA FERRER, in her official capacity as Director of the Los Angeles County Department of Public Health; MANUEL CARMONA, in his official capacity as the Director of Public Health for the Pasadena Public Health Department; LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH; and PASADENA PUBLIC HEALTH DEPARTMENT,

Defendants.

2:26-cv-03500-SPG-SP

DEFENDANT DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH ERICA PAN'S OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Date: May 27, 2026
Time: 1:30 p.m._
Courtroom: 5C
Judge: The Honorable Sherilyn Peace Garnett
Trial Date:
Action Filed: 4/02/2026

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INTRODUCTION

Plaintiff, Erica Jimenez, challenges as discriminatory on the basis of race the State's Black Infant Health (BIH) program, which is designed to address the public health crisis of significantly higher mortality rates of Black and African American mothers and their infants as compared to other demographics.

As a threshold matter, Plaintiff cannot establish that she has standing to seek a preliminary injunction because the record does not demonstrate that she actually sought admission to and was rejected from the BIH program, or that she would necessarily be denied participation in the program if she were to take the required steps to apply. For at least this reason, Plaintiff's preliminary injunction motion should be denied, and there is no need for the Court to address the substantive merits.

Even if Plaintiff were able to establish standing, the record does not support an equal protection claim because the California Department of Public Health (CDPH or the Department) does not have a policy of prohibiting otherwise qualified applicants from enrolling in the BIH program if they do not self-identify as Black or African American. While the program is designed to address an important public-health need of Black and African American women and infants, it does not discriminate based on race because participation is not limited to Black and African American applicants. Thus, strict scrutiny does not apply, and Plaintiff is not likely to succeed on the merits of her equal protection claim.

If the Court nevertheless disagrees that the program does not exclude participants based on their race, the BIH program survives strict scrutiny because the evidence amply demonstrates that it is narrowly tailored to advance the State's compelling interest in addressing the high infant and maternal mortality rates disproportionately impacting the Black community.

Finally, because Plaintiff has failed to establish imminent harm, the public interest weighs heavily against the issuance of a preliminary injunction, and in

favor of maintaining the status quo. Accordingly, the requested preliminary injunction should be denied.

FACTUAL AND PROCEDURAL BACKGROUND

I. PLAINTIFF'S ALLEGATIONS AND RELEVANT FACTS

According to her complaint, Plaintiff Erika Jimenez is a new mother who resides in Pasadena, California. ECF 1 (Complaint, ¶ 26). In March 2026, Jimenez gave birth to her first child. *Id*., ¶ 27. Plaintiff does not identify as Black, nor does she identify her infant as Black. *Id*., ¶ 28.

Before giving birth, Plaintiff completed the City of Pasadena's online interest form for the BIH program. ECF 1 (Complaint, ¶ 29). Plaintiff alleges that on February 27, 2026, she spoke with a City of Pasadena BIH coordinator who explained to her that she did not qualify for the BIH program and referred her to other resources. Jimenez Decl., ¶ 4. Yet, this bare allegation is belied by the testimony of the BIH representative who received the call from Ms. Jimenez. According to Ms. Scott's testimony, Plaintiff did not seek admission to the program, did not disclose her race during her call with the BIH coordinator, and was not denied, or told she had been denied, admission to the program. Decl. of McKenzie Scott, ¶ 9. Plaintiff was further advised of numerous other programmatic options that she could avail herself of in addition to BIH, consistent with the City's practice of providing such information to anyone seeking pregnancy/parenting support. *Id*., ¶¶ 6–8. Yet, there is no evidence that Plaintiff has chosen to pursue any of these alternative resources. *Id*., ¶ 12. Finally, the evidence establishes that CDPH does not deny admission to the program on the basis of race to potential, otherwise eligible applicants. Declaration of Rita Nguyen, M.D., in Support of Opposition to Preliminary Injunction (Nguyen Decl.), ¶¶ 45–52.

By this action, Plaintiff alleges a violation of the Equal Protection Clause and Title VI of the 1964 Civil Rights Act based on her alleged exclusion from the BIH

program. By her motion for preliminary injunction, Plaintiff seeks an order that would permit her to participate in the BIH program before she reaches six months postpartum and is ineligible for services. ECF 13-6 (Motion at 19:25-27).

II. CDPH IMPLEMENTS STATEWIDE PROGRAMS TO ENSURE THAT CALIFORNIA'S MOTHERS AND INFANTS RECEIVE QUALITY HEALTH CARE

A. CDPH's Assessments of the Health of Californians

CDPH is tasked with protecting and promoting the health of Californians through population-based health programs and services. CDPH operates under a framework established by California Health and Safety Code, sections 131000 *et seq.*, supported by regulations found in the California Code of Regulations, including Titles 17, 22, and 27. These statutory and regulatory provisions govern the Department's authority and duties to deliver public health services across the state with programs designed to address a broad range of population health issues, ensuring public safety and well-being through preventive and responsive health programs.

Title V was created to promote the health of mothers and children and reduce infant mortality through providing prenatal, delivery, and postpartum care for low-income, at-risk pregnant women, and to provide and promote family-centered, community-based coordinated care for children with special healthcare needs and their families. 42 U.S.C. § 701(a)(1)(A), (B), (D).

1. Data Sources that Support CDPH's Programs

CDPH uses many data sources to assess Californians' health, including vital statistics (i.e., births and deaths), surveillance systems and registries (e.g., reportable communicable/infectious diseases case and lab reporting systems, cancer registry), hospital discharge and emergency department visit data, administrative data, surveys, socioeconomic-related data, and others. Nguyen Decl., ¶ 8.

2. The Maternal, Child & Adolescent Health Division (MCAH)

MCAH, a division of CDPH, is focused on an array of efforts to monitor and improve the health and well-being of California's individuals and families. Nguyen Decl., ¶¶ 9–14. MCAH provides health information and data, creates programs to address public health issues, and administers funds to Local Health Jurisdictions (LHJs) and Community Based Organizations through contracts and/or allocation agreements. *Id*., ¶ 9. MCAH is staffed by a multi-disciplinary team of experts including doctors, nurses, social workers, epidemiologists, data analysts, scientists, and various other health professionals. *Id.*, ¶ 10. MCAH's scientific staff analyzes population-based data to measure and track disparities among California families, and the data is then used to inform strategic planning, programing, and funding decisions. *Id.*, ¶ 11.

The scientific and epidemiologic statistics provide the basis for MCAH's programs to investigate and address these disparities. Nguyen Decl., ¶¶ 15–16. Among these programs are the Black Infant Health (BIH) program and the Perinatal Equity Initiative. *Id.*, ¶ 30. California's "Momnibus" Act (Senate Bill 65, 2021) further codified this commitment to investments in Black maternal and infant health by requiring CDPH to establish the California Pregnancy-Associated Mortality Review Committee (CA-PARC), effective August 1, 2022, to review pregnancy-related deaths, analyze causes of severe maternal morbidity, and recommend prevention strategies—with explicit focus on disparities in maternal health. *Id.*

3. MCAH Mission and Programming

MCAH's mission is to provide health information, data, and programs in a culturally sensitive manner that are available to women and their infants. Nguyen Decl., ¶ 53. Each MCAH program is required to ensure the availability of a toll-free telephone system that provides a current list of culturally and linguistically

appropriate information and referrals to community health and human resources. *Id*. These resources provide public access to prenatal care. *Id*.

B. The Black Infant Health (BIH) Program

1. History of the Program

The BIH program was designed and expanded to address a public-health crisis: the significantly disproportionate risk of maternal and infant health outcomes for Black women compared with women and babies in other racial-ethnic groups. Nguyen Decl., ¶ 31.

In 1989, with the passage of Senate Bill 165, Budget Act of 1989, California began to more aggressively address the challenge of improving the health of Black women, infants, and children by providing services in a culturally supportive manner. Nguyen Decl., ¶ 31. Originally a pilot project at four sites, the BIH program expanded to reach 17 local health jurisdictions where over 90 percent of all Black infants are born in California. *Id*.

In 2006, CDPH/MCAH commissioned the University of California, San Francisco Center on Social Disparities in Health (UCSF/CSDH) to conduct an assessment of the BIH program. Nguyen Decl., ¶ 32. The assessment report found that, given the complex and multifaceted root causes of Black perinatal and infant health outcomes, there was no evidence to support any singular, specific, short-term solution to reduce adverse pregnancy and birth outcomes among Black women. *Id*. The BIH program expanded with the goal of developing a program reflecting current scientific knowledge about the individual and community-level factors that influence health and health disparities.

In 2011, CDPH/MCAH began implementing a standardized BIH program that features both (1) a group intervention designed to encourage empowerment and social support and promote health and healthy behaviors; and (2) enhanced one-to-one support to link participants with needed community and health-related services. Nguyen Decl., ¶ 35. The BIH program provides services in a culturally relevant

manner that respects participants' beliefs and cultural values while promoting overall health and wellness, recognizing that women's health and health-related behaviors are shaped by non-medical factors. *Id*.

2. Statistical Data that Supports the BIH Program

MCAH data demonstrates the existence of severe and persistent racial disparities in infant health outcomes in California, with Black mothers and infants experiencing significantly high perinatal and infancy health risks. Nguyen Decl., ¶¶ 17–29. For example, in 2023, the Black infant mortality rate was 8.75 deaths per 1,000 live birth—three times the White rate (2.90) and Asian rate (2.60), and twice the Hispanic rate (4.21). *Id*., ¶ 17. This disparity persists despite an overall 25% decline in the Black infant mortality rate since 2000. *Id.*

Preterm birth (PTB) and low birth weight (LBW) are among the leading causes of infant mortality. *See* Nguyen Decl., ¶¶ 43–44. In 2024, the PTB rate among Black infants (12.85%) was nearly double the White rate (7.73%), against a statewide overall rate of 9.07%. *Id.*, ¶ 18. The LBW rate among Black infants (12.69%) was more than double the White rate (5.84%), against a statewide overall rate of 7.40%. *Id.*, ¶ 18 & fn. 7.

Additionally, although the overall pregnancy-related mortality rate in California declined to 12.0 deaths per 100,000 live births in 2023, down from 21.6 in 2021 and 18.6 in 2020 during the COVID-19 peak, the Black birthing population bears a disproportionate burden. Nguyen Decl., ¶ 19. Averaged over 2021–2023, the pregnancy-related mortality rate among Black birthing individuals was 57.8 per 100,000 live births—3.6 times the White rate (15.9), 4.0 times the Hispanic rate (14.3), and 4.3 times the Asian rate (13.3). *Id*. And Severe Maternal Morbidity (SMM) disproportionately affects Black mothers[1]. *Id.* In 2024, the SMM rate among Black mothers was 185.9 events per 10,000 delivery hospitalizations, 76%

[1] Use of the terms "Black" "mothers" and "women" is intended to include Black and African American individuals, and birthing individuals who do not identify as women or mothers.

higher than the White rate of 105.6. In 2023, the prevalence of hypertension at delivery among Black women (19.3%) was 33% higher than among White women (14.5%). *Id*.

3. Governing Concepts of the BIH Program

All aspects of the BIH program have been developed with attention to four key governing concepts: 1) services are provided in a culturally relevant manner providing care to people with diverse values, beliefs and behaviors, including tailoring delivery to meet participants' social, cultural, and linguistic needs; 2) a client-centered, interactive approach focused on developing goals and strategies that are personalized and realistic; 3) a collaborative strength-based approach that acknowledges individual strengths to foster growth and healthy behavior change; and 4) cognitive skill-building through cognitive behavioral therapy (CBT) that aims to solve problems through a goal-oriented process. Nguyen Decl., ¶ 39.

4. Impact of the BIH Program

Pregnant women who enroll in the BIH program receive basic assistance (diapers, baby items, transportation assistance) as well as culturally relevant services. Nguyen Decl., ¶ 40. Enrollees participate in 10 weekly group sessions during pregnancy and 10 weekly postpartum group sessions with other new mothers, and work individually with BIH program staff to develop life-plans. *Id*. All group facilitators are trained by CDPH and MCAH. *Id*.

Importantly, the group-based program sessions are designed to provide participants with a culturally affirming environment to help participants enhance life skills, learn strategies for reducing stress, and build social support. Nguyen Decl., ¶ 41. The BIH program specifically seeks to address racial and socioeconomic disparities in maternal health, recognizing through data-driven research that access to care, resources, and support are not equal for all mothers. *Id*.

5. Participation in the BIH Program

Although the program is geared towards addressing the needs of the self-identifying Black and African-American population, who otherwise fall within gestational and post-birth timing parameters, if a prospective participant who does not identify as Black meets these eligibility criteria, and local BIH program staff believe that the individual would benefit from participation in the program, the BIH program representative will contact their designated MCAH-BIH Program Consultant (PC) to facilitate the person's admission. Nguyen Decl., ¶ 43.

C. Culturally Specific Interventions

CDPH elected to focus on culturally specific interventions to provide critical supports that participants can utilize to remain physically and mentally well during pregnancy, postpartum, and beyond, and ultimately contribute to improving adverse outcomes. Nguyen Decl., ¶ 44. This culturally sensitive focus encourages participation in, and contributes to, positive program outcomes. *Id.* It also encourages interpersonal trust within the groups and trust with the government institution. The BIH program would not be as successful at targeting the disparity in infant mortality and health outcomes in the Black community were it, as compared to other available programs, not to encourage the enrollment of participants who self-identify as Black or African American. *See* ECF 24-1 (Declaration of Dr. Melissa Franklin in Support of County Defendants' Opposition to Plaintiff's Motion for Preliminary Injunction (Franklin Decl.), ¶ 26.)

D. Comparable Programs and Resources Through the State and LHJs

MCAH's overriding mission to provide health information, data, and programs means that MCAH provides other programmatic options, including culturally sensitive programs, that are available to women and their infants who do not qualify for or are not interested in participation in the BIH. Nguyen Decl., ¶ 53–55. These programs include the Local Maternal, Child and Adolescent Health

Program (offered through the cities and counties) and the California Home Visiting Programs (CHVP), which, in turn, includes Family Connects, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. *Id*., ¶ 54.

These programs offer similar services and supports to improve maternal, infant, and/or child-health outcomes and are available to people who meet the eligibility requirements for them. Specific services include referrals to resources, nurse home visiting, and provision of necessary resources to participants. Nguyen Decl., ¶ 55. In Los Angeles County, for example, there are more than 20 different programs overseen by the County's local MCAH Director, aimed at providing support to mothers and infants. Franklin Decl., ¶ 49. While the BIH program serves 450 people per year in Los Angeles County, the other programs for expecting or new mothers, infants, and families overseen by Los Angeles County serve approximately 45,000 people per year. *Id*. County and community programs that serve mothers and infants including the Home Visiting Program, Project HOPE, MAMA's Neighborhood, CHOI, and Shields for Families would have been, and may still be, available to Plaintiff. *Id*., ¶ 64.

In sum, MCAH is designed to be an evidence-based but flexible program that meets the needs of pregnant women. CDPH and its partners work with prospective enrollees to find the best fit for their needs.

APPLICABLE LEGAL STANDARD

A preliminary injunction is an "extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008) (*Winter*). A movant seeking a preliminary injunction must establish that: (1) the movant is likely to succeed on the merits; (2) the movant is likely to suffer irreparable harm absent preliminary relief; (3) the balance of equities tips in the movant's favor; and (4) an injunction is in the public interest. *Id.* at 20. "When the government is a party, these last two

factors merge." *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014).

As the moving party, Jimenez bears the burden of proving each of these elements. *See Klein v. San Clemente*, 584 F.3d 1196, 1201 (9th Cir. 2009). If a movant fails to establish a likelihood of success, the court "need not consider the remaining three [*Winter* elements]." *Garcia v. Google, Inc.*, 786 F.3d 733, 740 (9th Cir. 2015) (en banc) (quoting *Ass'n des Eleveurs de Canards et d'Oies du Quebec v. Harris*, 729 F.3d 937, 944 (9th Cir. 2013)).

In this case, because Plaintiff's proposed injunction constitutes a mandatory injunction, she has a "doubly demanding" burden to establish that the law and facts "clearly favor" her position. *See Garcia*, 786 F.3d at 740; *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009). Any injunction, if ordered, must "be narrowly tailored to give only the relief to which plaintiffs are entitled." *Orantes-Hernandez v. Thornburg*, 919 F.2d 549, 558 (9th Cir. 1990).

ARGUMENT

I. AT THE THRESHOLD, PLAINTIFF LACKS STANDING TO SEEK PRELIMINARY INJUNCTIVE RELIEF

Plaintiff fails to show that she has suffered an injury in fact sufficient to confer standing for her to bring this lawsuit. "'The party invoking federal jurisdiction'" bears the burden of establishing the elements of standing. *American Encore v. Fontes*, 152 F.4th 1097, 1110 (9th Cir. 2025) (quoting *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992)). When seeking a preliminary injunction, "'the plaintiff must make a "clear showing" that she is likely to establish each element of standing.'" *Id.* (quoting *Murthy v. Missouri*, 603 U.S. 43, 58 (2024)). At the preliminary-injunction stage, the Court may consider evidence beyond the four corners of the complaint to determine whether the plaintiff has met her burden to show standing. *See, e.g., California Trucking Association v. Bonta* 996 F.3d 644,

652–653 (9th Cir. 2021). And where a plaintiff lacks standing to bring litigation, she has no likelihood of succeeding on the merits of her claims to justify preliminary injunctive relief. *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 102; *Associated Gen. Contractors of Cal., Inc. v. Coal. for Econ. Equity*, 950 F.2d 1401, 1405 (9th Cir. 1991).

To establish standing, a plaintiff must demonstrate: (1) a concrete and particularized injury in fact; (2) a causal connection between the injury and defendant's conduct; and (3) a likelihood that the injury will be redressed by a favorable decision. *Lujan*, 504 U.S. at 560-61 (1992). To meet the injury-in-fact requirement, a plaintiff must demonstrate an invasion of a legally protected interest that is both (1) "concrete and particularized" to them and (2) "actual or imminent," and not hypothetical or conjectural. *Id.* at 560. Where prospective injunctive relief is sought, an alleged threatened injury must be "certainly impending." *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409 (2013). A plaintiff has not shown concrete injury if their claims rest solely on an "abstract injury" stemming from "only a general legal, moral, ideological, or policy objection to a particular government action." *Food & Drug Admin. v. All. for Hippocratic Med.*, 602 U.S. 367, 381 (2024).

Here, Plaintiff, on multiple grounds, fails to, and cannot, establish an injury in fact. Firstly, despite her testimony to the contrary, Plaintiff did not seek to enroll in the Pasadena BIH, but stopped at merely submitting an interest form and having an informational call with a Community Services Representative, Ms. Scott. Decl. of McKenzie Scott, ¶¶ 3–6. Submission of an interest form is just a preliminary step before moving forward with the enrollment process, which includes various assessments and completion of the process. *Id.*, ¶ 10. Furthermore, Plaintiff was not, and was not told she had been, denied participation in the program, nor was she asked to identify her race during the call. *Id.*, ¶¶ 6, 9–10. Indeed, Ms. Scott would not have told Plaintiff that she was ineligible during that initial call because that is

not her training or her practice. *Id*., ¶ 10. Only after a prospective applicant has completed the assessment and enrollment process would they be confirmed as admitted to the program. *Id*.

Further, Plaintiff has not presented any evidence that she would have been rejected from the program on the basis of her self-identified race if she had actually sought to enroll. *See* Nguyen Decl., ¶¶ 45–52. CDPH does not have or encourage any policy to reject an applicant to the program based on their race; indeed, its own recruitment form does not include any language requesting the prospective participant's race or contain any boxes to record the potential participant's race. *Id*. ¶¶ 45–46. CDPH is also not aware of anyone being turned away, rejected, or disenrolled from the program on the basis of race, including the plaintiff in this case, Erica Jimenez. *Id*., ¶ 45–52. If Ms. Jimenez, or any other person who does not self-identify as Black or African American, sought to participate in the program, and local BIH staff believe that she would benefit from participation in the program, local BIH staff could enroll the participant regardless of their self-identified race. Nguyen Decl., ¶¶ 45–52; Scott Decl., ¶ 11. Under these facts—Plaintiff's failure to pursue admission to the program, that Plaintiff has not been denied admission to the program, and that her race would not preclude her admission to the program—Plaintiff cannot allege a concrete, "certainly impending" injury caused by the Pasadena BIH based on exclusion from the program that could support a preliminary injunction.

Moreover, the factual dispute based on the differing descriptions by Plaintiff and Ms. Scott of what was said during their single phone call, which is relevant to whether Plaintiff has standing to bring this action, weighs against the requested relief in light of Plaintiff's burden to make a "clear showing" that she is likely to establish each element of standing when seeking a preliminary injunction.

Finally, even assuming the truth of Plaintiff's testimony—that she applied for and was told she was ineligible for the BIH program because she does not identify

as Black—Plaintiff has still failed to establish any injury. Plaintiff admits that she was advised of and directed to other available maternity programs and resources for pregnant mothers and infants, and it is undisputed that other such programs and resources exist. ECF 13-5 (Jimenez Decl., ¶ 4); ECF 13-6 (motion at 11); Nguyen Decl., ¶¶ 53-58; Franklin Decl., ¶¶ 49–64; *see also* Scott Decl., ¶¶ 6–8. Yet Plaintiff makes no mention of what services she wanted to receive or whether she took any steps to pursue any of those program alternatives in an effort to obtain those services. Indeed, it is not clear what exactly Plaintiff believes she is being deprived of because she did not testify that she wants any particular services, including those that could only be accessed through the BIH. ECF 13-5 (Jimenez Decl., ¶ 6). Further, no other evidence independently supports the notion that she pursued alternative program options. Scott Decl., ¶ 12. Thus, because Plaintiff did not seek out any of the alternative prenatal and postpartum services available to her, she cannot show an injury in fact resulting from her alleged exclusion from those services. In other words, her claimed lack of access to programmatic supports is a "harm" entirely of her own making. *Cf. Al Otro Lado v. Wolf,* 952 F.3d 999, 1008 (9th Cir. 2020.)

For at least these reasons, Plaintiff lacks standing to move for preliminary injunctive relief, and her motion should be denied on that basis.

II. PLAINTIFF IS NOT LIKELY TO SUCCEED ON THE MERITS OF HER EQUAL PROTECTION OR TITLE VI CLAIMS.

Even if Plaintiff established standing to bring this action and to seek a preliminary injunction, she cannot show she is likely to succeed on the merits of her Equal Protection or Title VI claims. For this additional reason, the motion should be denied.

Firstly, the challenged governmental program does not discriminate on the basis of race. The threshold requirement for a race-based equal protection claim is that the challenged governmental action, either on its face or in its manner of

enforcement, "results in members of a certain group being treated differently from other persons based on membership in that group." *McLean v. Crabtree*, 173 F.3d 1176, 1185 (9th Cir. 1999). Plaintiff has not made this showing.

A. Plaintiff Is Not Likely to Prevail on the Merits of Her Equal Protection Claim

1. Strict Scrutiny Does Not Apply Here Because CDPH Does Not Have a Policy of Prohibiting People from Enrolling in the BIH Program Based on Race

Even if Plaintiff had alleged a desire to enroll in the BIH to obtain some unnamed service or support, she has not met her burden of establishing that CDPH has a policy of excluding individuals from the program who do not identify as Black or African American.

The "central purpose of the Equal Protection Clause is to prevent the States from purposefully discriminating between individuals on the basis of race." *Hunter ex rel. Brandt v. Regents of Univ. of Cal.*, 190 F.3d 1061, 1069 (9th Cir. 1999) (internal quotations omitted). Here, CDPH does not enforce any policies that would require local BIH sites to prohibit individuals from entering the program, or require individuals to be disenrolled, and it is not CDPH's intent that local BIH programs exclude otherwise eligible individuals from participation based on their race. Nguyen Decl., ¶ 46. Nor does CDPH have any quality control measures, or reporting or review processes, that would require BIH sites to decline admission to or disenroll individuals based on racial criteria. *Id.*, ¶ 47. Consistent with this policy and practice, as noted above, the BIH recruitment form used for all prospective BIH participants does not include a request for that person's race. *Id.*, ¶ 48. In other words, CDPH does not require individuals who do not self-identify as Black or African American to be rejected by local BIH sites. *Id.*, ¶ 45–52.

With respect to actual implementation of the BIH, CDPH program staff are unaware of any instances of an otherwise qualified individual who sought to participate in BIH programs or services but was excluded based on race. Nguyen

Decl., ¶ 45, 49, 51. To the contrary, a number of previous BIH participants who did not self-identify as Black or African American have been enrolled at local sites. *Id.*, ¶ 50.

In sum, while the BIH is a program designed to specifically address the unique needs of Black and African American pregnant women and infants with the goal of reducing the disproportionately high infant mortality rate and improving maternal health outcomes in that community, it is not CDPH's policy or practice to deny participation to women of other races who want to take part in it. Nguyen Decl., ¶¶ 45–52.[2] Thus, the record does not establish that Plaintiff, or any other woman who does not identify as Black or African American, is being discriminated against based on her race in access to program services. At most, the record supports the conclusion that CDPH has developed programming that directly addresses and supports concerns surrounding disparities in Black maternal and infant health.

Because the BIH program does not prohibit participation on the basis of race, it does not violate the Equal Protection clause. Accordingly, Plaintiff has not met her burden of proof to be entitled to preliminary injunctive relief.[3]

[2] Race-conscious focused outreach and program design does not an implicate equal protection claim. *See, e.g., Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701, 789 (2007) ("School boards may pursue the goal of bringing together students of diverse backgrounds and races through other means, including strategic site selection of new schools; drawing attendance zones with general recognition of the demographics of neighborhoods; allocating resources for special programs; recruiting students and faculty in a targeted fashion; and tracking enrollments, performance, and other statistics by race. These mechanisms are race conscious but do not lead to different treatment based on a classification that tells each student he or she is to be defined by race, so it is unlikely any of them would demand strict scrutiny to be found permissible.")

[3] Moreover, because there are multiple entry-points to similar types of pregnancy and post-partum resources funded by the State through the MCAH Program, whether through the BIH program or another program or initiative within the umbrella program, the principles cited by Plaintiff for her claim of discrimination are fundamentally misplaced. That is, unlike affirmative action programs using race-based criteria that may result in the denial of admission to a university, the MCAH program does not result in exclusion from access to its services based on race. In other words, access to MCAH program services does not implicate the type of "zero-sum" issue present in mandatory college admissions criteria. *See, e.g., Students for Fair Admissions, Inc. v. President and Fellows of*

(continued…)

2. The BIH Survives Strict Scrutiny Because It Is Narrowly Tailored to a Compelling Governmental Interest.

Even if the Court were to conclude that the BIH program discriminates based on race—which it should not—Plaintiff's claims fail because the BIH nevertheless survives strict scrutiny. This is because the BIH program is narrowly tailored to address the State's compelling public health interest in improving and supporting the health of mothers and infants.

"[A]ll racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny." *Adarand Constructors, Inc. v. Pena* 515 U.S. 200, 227 (1995). A race-based state action passes strict scrutiny if (1) it serves a compelling governmental interest; and (2) it is narrowly tailored to fulfill that interest. *Hunter*, 190 F.3d at 1063. The BIH satisfies both elements of this analysis.

a. The BIH Program Serves the State's Compelling Interest in Supporting Maternal Health and Reducing the Disproportionately High Infant and Maternal Mortality Rate in the Black Community

CDPH and its co-defendant local partners have a compelling interest in supporting and improving the health of mothers and infants in the State, which necessarily includes addressing the public health crisis of the disproportionately high rates of Black infant mortality and pregnancy mortality for Black mothers.

It is well-established that States have a compelling interest in protecting and supporting public health, and addressing public health crises. *See, e.g.*, *Buchwald v. University of New Mexico School of Medicine*, 159 F.3d 487, 498 (9th Cir. 1998) ("public health is a compelling government interest"); *Globe Newspaper Co. v.*

Harvard Coll., 600 U.S. 181, 219 (2023) (*Students for Fair Admissions, Inc.*) ("College admissions are zero-sum. A benefit provided to some applicants but not to others necessarily advantages the former group at the expense of the latter.") Because the MCAH program does not prevent non-Black individuals from accessing its services and supports for expectant and new mothers, Plaintiff's Equal Protection claim fails.

Superior Ct. for Norfolk County, 457 U.S. 596, 607 (1982) (recognizing a compelling government interest in "safeguarding the physical and psychological well-being of a minor")*; Roman Cath. Diocese of Brooklyn v. Cuomo,* 592 U.S. 14, 18 (2020) (stemming the spread of COVID-19 is unquestionably a compelling interest); *Jacobson v. Massachusetts,* 197 U.S. 11, 25 (1905) (state has a "compelling" interest in protecting the health and safety of its residents, including the students in its schools, by preventing the spread of communicable diseases.) As previously observed by the Supreme Court, "it may be assumed that in some situations a State's interest in facilitating the health care of its citizens is sufficiently compelling to support the use of a suspect classification." *Regents of the Univ. of Cal. v. Bakke,* 438 U.S. 265, 310 (1978). The Ninth Circuit has similarly stated that, in the context of medical treatment, "[i]t is not difficult to imagine the existence of a compelling justification" for race-based classifications. *Mitchell v. Washington*, 818 F.3d 436, 446 (9th Cir. 2016).

The disproportionately high mortality rates affecting Black mothers and infants across income levels is a readily-observable, empirical fact supported by extensive data. Nguyen Decl., ¶¶ 17–29; Franklin Decl., ¶¶ 17–27. Indeed, Plaintiff's complaint concedes this reality. ECF 1 (Compl., ¶ 16.) Thus, substantial scientific evidence and data establishes the existence of a significant public health issue that the State clearly has a significant interest in addressing. Nguyen Decl., ¶¶ 17–29; Franklin Decl., ¶¶ 17–27. Moreover, this public health crisis is the precise kind of "at-risk" issue Congress intended to address in granting California Title V funding. 42 U.S.C. § 701(a)(1)(A), (B), (D). The California Legislature recognized the compelling need to address the disparity between Black and non-Black populations in infant mortality. In establishing the BIH Program, it set forth findings that "there continues to be a statewide gap between mortality rates for Black infants and those for other population groups," and that "the rate of mortality

among Black infants continues to be two to four times higher than the rates for other groups statewide." Cal. Health & Saf. Code § 123259(a).

Plaintiff argues that "the only compelling interest applicable to BIH is remedying specific, identified instances of past discrimination that violated the Constitution or a statute," and that CDPH lacks the required evidence of specific instances of past discrimination to justify the BIH. ECF 13-6 (Mot. at 12-13) (*citing Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 206-07 (2023).) But Plaintiff's exclusive reliance on the line of Supreme Court cases addressing racial preferences in school admissions to argue that Defendants here must make a showing of specific examples of past discrimination is fundamentally misplaced. *Id*. As discussed above, the BIH is not an affirmative action program, and its goal is not to remedy past discrimination against Black mothers; it is, instead, a public-health initiative designed and targeted to mitigate and remedy a public-health emergency that is ongoing, very much of the moment, and the result of numerous factors and variables. Accordingly, the relevant analysis here is whether CDPH has a compelling interest in addressing a particularly pernicious public health and welfare issue. Unlike affirmative action programs to prioritize the admission of students of certain races for the express purpose of redressing past racial discrimination, the BIH Program was established to help mitigate, and eventually eliminate, a public health crisis.

While racism has been identified as one of the reasons that the health of Black mothers and infants is disproportionately impacted, (*see, e.g.,* Nguyen Decl., ¶¶ 20–21), the BIH Program is not designed to remediate past discrimination, but rather is intended to improve health outcomes right now and moving forward. *See* Nguyen Decl., ¶ 16; Franklin Decl., ¶¶ 19–27. As the Ninth Circuit explained in *Hunter*, 190 F.3d at 1064 fn. 6, the particular analysis used for race-based remedial programs does not extend to the use of race for other, non-remedial purposes.

In *Hunter*, the appellant argued that only an interest in remedying past discrimination could justify the use by an elementary school operated as a research lab at UCLA's Graduate School of Education and Information Studies of race/ethnicity as a factor in its admissions process. The court rejected that argument as simply wrong, stating that, "[t]he Supreme Court has never held that only a state's interest in remedial action can meet strict scrutiny," nor had the Ninth Circuit. *Id*. at fn. 6. Instead, the Ninth Circuit made clear that its prior rulings concluded only that, in the particular case "where the asserted state interest *is* remedying past discrimination, this remedial interest must be supported by concrete evidence of discrimination." *Id*. (emphasis in original).[4] This is not one of those cases: CDPH is not seeking to remedy past discrimination, but is focused on furthering the public health and welfare, including in large part through developing programs to address particular issues affecting particular populations on a daily basis, namely, in this case, Black women who are dying at disproportionately high rates due to pregnancy and Black infants,

In sum, the Supreme Court's holdings that a strong evidentiary basis is needed to support an interest in remedying past discrimination in the affirmative action context simply have no bearing on the question whether a non-remedial interest, such as, for example, "the operation of a research oriented elementary school dedicated to improving the quality of education in urban public schools, can serve as a compelling interest sufficient to survive strict scrutiny." *Hunter*, 190 F.3d at 1064 fn 6. The State's non-remedial interest here in improving the health of Black

[4] The Supreme Court's recent decision, *Louisiana v. Callais*, 2026 WL 1153054, *10, explained that the Court's precedents had identified two compelling interests to date that can satisfy strict scrutiny, one of which is "remediating specific, identified instances of past discrimination that violated the Constitution or a statute," which Plaintiff argues applies here. But the Supreme Court used the opportunity to examine "whether compliance with the Voting Rights Act should be added to our very short list of compelling interests that can justify racial discrimination," thus confirming that the two compelling interests previously identified in the race-based discrimination context are not intended to foreclose consideration of whether other compelling interests can satisfy strict scrutiny. *Id.*

mothers and infants facing a significant mortality rate problem is a compelling interest that does not require a showing of past discrimination to survive strict scrutiny.

CDPH's evidence amply demonstrates that the BIH program furthers the State's compelling interest in mitigating a serious public health problem.

b. The BIH Program Is Narrowly Tailored to Serve the State's Compelling Public Health Interest

The BIH program is also narrowly tailored to serve CDPH's compelling interest in in reducing the high mortality rates of pregnant Black mothers and their infants.

The BIH program addresses a critical, endemic health concern for a significant demographic in California, and does so under a framework that is empirically justified by research, studies and data. Nguyen Decl., ¶¶ 31–41; Franklin Decl., ¶¶ 22–25. As the evidence demonstrates, the BIH is comprised of numerous components specifically geared towards addressing this unique problem. To better meet the health-related needs of pregnant and postpartum Black women and their infants, the program features both: (1) a group intervention designed to encourage empowerment and social support in the context of a life course perspective; and (2) enhanced one-to-one support to link participants with needed community and health-related services. Nguyen Decl., ¶ 35. This program thus provides services in a culturally relevant manner that respects participants' beliefs and cultural values while promoting overall health and wellness, recognizing that women's health and health-related behaviors are shaped by non-medical factors (e.g., the effects of stress related to limited social and economic resources as well as racism and discrimination). *Id*.

A program that is not designed to address the specific needs of Black mothers and infants would not effectively address the pregnancy and infant mortality crisis. A program based solely on socioeconomic factors would not be as effective,

because the evidence shows that the health risks to Black women and infants exist across income and education lines. Nguyen Decl., ¶¶ 17–28, 36; Franklin Decl., ¶18. The evidence also shows that other types of interventions have not been successful in addressing this public health issue. Franklin Decl., ¶¶ 21-22, 26.

Also, the program provides Black mothers with health-related information in a culturally appropriate manner that is cognizant of internalized racism to increase engagement of this subpopulation with the program. Nguyen Decl., ¶ 35.

In sum, the State has determined, based on the research and data, that the BIH program is needed to adequately address the public health crisis of disproportionately high mortality rates and other adverse health outcomes affecting pregnant Black women and infants, and that a more generalized program lacking such a focus would not be as effective at achieving that goal. As the Ninth Circuit has emphasized, in evaluating whether the use of race/ethnicity in a program is narrowly tailored, courts should avoid second guessing and defer to the legitimate informed judgments of researchers and academics regarding what is needed to achieve their goal. *Hunter*, 190 F.3d at 1066-67 (observing that "no one would challenge" a decision of medical school to explicitly consider ethnicity when selecting study participants for research that occurs predominately in a particular population, such as limiting participants to Black children for a study on the prevention of sickle-cell anemia). *Id*., n.11. Further, narrow tailoring "does not require exhaustion of every conceivable race-neutral alternative." *Grutter v. Bollinger,* 539 U.S. 306, 339 (2003),

That the BIH program is narrowly tailored is further evidenced by the fact that CDPH policy permits an otherwise qualified woman to participate in the program even if she does not self-identify as Black or African American. *See* Section II.A.1, *supra*. This evidence contradicts Plaintiff's unsupported allegation that "BIH's racial eligibility cannot be waived," and that the "program's criteria do not provide any flexibility that would allow a non-black mother of a non-black infant to

participate." ECF 13-6 (Mot. at 15). Thus, the BIH does not categorically or inflexibly exclude individuals based solely on race. See *Western States Paving Co., Inc. v. Washington State Dept. of Transp*., 407 F.3d 983, 993 (9th Cir. 2005).

Plaintiff also argues that the BIH program is not subject to reasonable durational limits. ECF 13-6 (Mot. at 16) (citing *Students for Fair Admissions, Inc.*, 600 U.S. at 227-228.) As discussed above, however, this case is distinguishable from *Students for Fair Admissions* and other affirmative action cases that discuss the need for a logical end point in the context of a race-based affirmative action program. In any event, the BIH program has 5-year goals and logical end points informed by the program's success in achieving its stated goals. For example, it aims to reduce negative health outcomes for Black women and Black infants by 2030 by specific and measurable amounts. Nguyen Decl., ¶ 38; *Cf. Students for Fair Admissions, Inc.*, 600 U.S. at 214 (race-related admissions goals failed because those goals were neither "sufficiently coherent" to survive strict scrutiny, nor readily measurable).[5]

For these reasons, Plaintiff is unlikely to succeed on the merits of her Equal Protection claim.

B. Because the BIH Program Does Not Impose a Racial Classification that Violates the Equal Protection Clause, Plaintiff's Title VI Claim Is Not Likely to Succeed on the Merits

For the same reasons discussed above, Plaintiff's Title VI claim fails.

Title VI prohibits discrimination "under any program or activity receiving Federal financial assistance" on the basis of "race, color, national origin." 42

[5] Plaintiffs argue that the BIH program uses the race of non-Black applicants and their babies as a negative by "categorically" excluding them from the program on that basis. ECF 13-6 (Mot. at 15.) But, as previously discussed, the program does not categorically exclude non-Black applicants. Instead, CDPH has a policy not to exclude on the basis of race individuals who want to be part of the program and otherwise meet program criteria. Nguyen Decl., ¶¶ 45–52. In addition, Plaintiffs' argument that the State is using race as a stereotype is wholly misplaced. *See id*. As set forth above, the program's focus on supporting Black and African American participants with culturally relevant material is based on scientific data and empirical evidence establishing a public health crisis that affects Black women and their infants across socioeconomic lines, not on any stereotypes.

U.S.C. § 2000d. But Title VI "'on its own bottom reaches no further than the Constitution.'" *Payan v. Los Angeles Cmty. Coll. Dist.*, 11 F.4th 729, 736 (9th Cir. 2021) (quoting *Guardians Ass'n v. Civ. Serv. Comm'n of New York*, 463 U.S. 582, 589–590 (1983)). Thus, Title VI only bars "'racial classifications that would violate the Equal Protection Clause or the Fifth Amendment.'" *Id.* (quoting *Bakke*, 438 U.S. at 287.)

Here, as discussed above, the BIH program satisfies strict scrutiny because it is narrowly tailored to serve a compelling governmental interest in addressing the significant public health crisis facing Black mothers and infants. There is, therefore, no Equal Protection violation. Because Plaintiff lacks a viable Equal Protection claim, and does not raise a Fifth Amendment claim, Plaintiff's Title VI claim against the BIH program also fails.

III. PLAINTIFF FAILS TO SHOW THAT SHE FACES LIKELY IRREPARABLE HARM DUE TO HER ALLEGED EXCLUSION FROM THE BIH PROGRAM

Here, for many of the same reasons she lacks standing, Plaintiff cannot establish that she faces irreparable harm. To obtain a preliminary injunction, the movant "must establish that irreparable harm is *likely*, not just possible[.]" *Ctr. for Food Safety v. Vilsack*, 636 F.3d 1166, 1172 (9th Cir. 2011) (emphasis in original) (internal citations omitted). Plaintiff cannot make such a showing.

First, Plaintiff cannot establish that she will suffer imminent harm absent an injunction, because, as discussed above, CDPH does not have a policy of prohibiting otherwise qualified people who do not identify as Black or African American from participating in the program, and she has not yet sought admission to the program. *See* Argument sections I, II.A, *supra*. The City of Pasadena's evidence instead establishes that Plaintiff has not yet applied for, been considered for, or been rejected from participation. See *id*. Nothing is preventing Plaintiff from applying for the BIH program now.

Second, Plaintiff may also avail herself of other comparable resources and supports offered by CDPH and its partners; to date, no evidence exists to suggest she has done so. Indeed, as previously noted, although Plaintiff admits that the City informed her of other maternal and infant resources and services, she fails to establish, and the record does not demonstrate, that she has attempted to pursue them in any way.

Defendants offer a variety of other resources for pregnant mothers and infants that are similar to the ones she seeks from the BIH Program. Nguyen Decl., ¶¶ 53–57; Franklin Decl., ¶¶ 49–65; Scott Decl., ¶¶ 6–8. Plaintiff concedes that she was informed about other resources when she spoke to a program representative from Pasadena, but she does not testify that she has actually availed herself of any of them. Jimenez Decl., ¶ 4. As noted above, self-created harms, such as Plaintiff's failure to seek similar services offered to her through other MCAH or LA County or City of Pasadena programs, do not constitute irreparable harm. *Al Otro Lado*, 952 F.3d at 1008; *Second City Music Inc. v. City of Chicago, Ill.*, 333 F.3d 846, 850 (7th Cir. 2003).

IV. BECAUSE THE BIH PROGRAM PROMOTES THE HEALTH AND SAFETY OF BLACK MOTHERS AND INFANTS, THE PUBLIC INTEREST WEIGHS AGAINST JIMENEZ'S REQUESTED PRELIMINARY INJUNCTION

The public interest heavily weighs in favor of the State's important public health program, and against any attempt to alter the BIH program's focus on addressing the high rate of pregnancy-related and infant mortality impacting Black mothers and infants.

The public interest "weighs strongly" in favor of denying injunctive relief regarding state actions and policies that "promote the health and safety" of the public. *Doe v. San Diego Unified Sch. Dist.* (9th Cir. 2021) 19 F.4th 1173, 1181 (9th Cir. 2021) (public interest weighed against enjoining school district's vaccine mandate because the vaccines administered under that mandate were "safe and effective at preventing COVID-19"). Here, the public interest weighs against

altering the content and focus of the BIH program, which promotes statewide the health of a significant at-risk population, to the extent that is what Plaintiffs seeks through this litigation.

The BIH program was specifically designed to meet the needs of that at-risk population and improve their pregnancy-related health outcomes, including by creating a culturally sensitive framework that encourages Black mothers to engage with the program in the first place. Nguyen Decl., ¶¶ 38, 55. The program has already seen some success in reducing the mortality and other pregnancy-related risks detrimentally impacting Black mothers and infants across socioeconomic levels, but the problem remains. *Id*., ¶ 38 & fns. 31, 36. Thus, and as detailed by the supporting declarations of Dr. Rita Nguyen and Dr. Melissa Franklin, the BIH program would not be as successful at addressing the disparity in the pregnancy-related and infant mortality rates in the Black community without its focus on Black and African American women and infants. Nguyen Decl., ¶¶ 32, 44; Franklin Decl., ¶¶ 24-27. Thus, if the program is enjoined in its current form, it appears likely that the significant health risks to that group would not be adequately addressed, causing serious harm to public health in this State.[6]

CONCLUSION

For the foregoing reasons, Plaintiffs' motion for preliminary injunction should be denied.

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[6] To the extent the Court is inclined to grant Plaintiff's motion, the consequential injunctive relief should be limited to Plaintiff only. "[D]istrict courts likely lack authority to issue 'universal injunctions'—orders that 'prohibit enforcement of a law or policy against anyone'—to the extent 'broader than necessary to provide complete relief to each plaintiff.'" *Vasquez Perdomo v. Noem*, 148 F.4th 656, 686 (9th Cir. 2025) (*quoting Trump v. CASA, Inc*., 606 U.S. 831, 837, 861 (2025)). Here, Plaintiff has not established sufficient grounds for provisional class certification or otherwise shown any harm to putative class members. Indeed, to date, she has not sought any such certification—provisionally or otherwise—from the Court. *See* Fed. R. Civ. P. 23. Thus, any injunctive relief issued by this Court need not extend any further than Plaintiff herself, in order to afford her the complete relief she requests, which is to participate in the BIH program. *See, e.g*., P.I. Mot. at 19:25-27.

Dated: May 6, 2026

Respectfully submitted,

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CERTIFICATE OF SERVICE

Case Name: **Erica Jimenez v Dr. Erica Pan, et al.** No. **2:26-cv-03500**

I hereby certify that on May 6, 2026, I electronically filed the following documents with the Clerk of the Court by using the CM/ECF system:

1. **DEFENDANT DIRECTOR OF THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH ERICA PAN'S OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**
2. **DECLARATION OF RITA NGUYEN, M.D. IN SUPPORT OF OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION**
3. **DECLARATION OF MCKENZIE SCOTT IN SUPPORT OF OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION**
4. **[PROPOSED] ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION [ECF NO. 13]**

I certify that **all** participants in the case are registered CM/ECF users and that service will be accomplished by the CM/ECF system.

I declare under penalty of perjury under the laws of the State of California and the United States of America the foregoing is true and correct and that this declaration was executed on May 6, 2026, at Los Angeles, California.

J. Sissov	*/s/ J. Sissov*
Declarant	Signature

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IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

ERICA JIMENEZ, individually and on behalf of a class of similarly situated individuals, Plaintiff, **v.** **DR. ERICA PAN, in her official capacity as Director of the California Department of Public Health; DR. BARBARA FERRER, in her official capacity as Director of the Los Angeles County Department of Public Health; MANUEL CARMONA, in his official capacity as the Director of Public Health for the Pasadena Public Health Department; LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH; and PASADENA PUBLIC HEALTH DEPARTMENT,** Defendants.	2:26-cv-03500-SPG-SP **DECLARATION OF RITA NGUYEN, M.D. IN SUPPORT OF OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION** Judge: The Honorable Sherilyn Peace Garnett Trial Date: Action Filed: 4/02/2026

I, Rita Nguyen, declare:

1. I am over the age of 18 years, a resident of the State of California, a U.S. citizen, and the Assistant State Public Health Officer with the California Department of Public Health. I know the following facts based on my own personal knowledge, and, if called as a witness, I could and would testify competently to the truth of the matters set forth herein.

Background and Experience

2. I received my M.D. at Johns Hopkins University School of Medicine and B.A. from Stanford University. I completed my Internal Medicine Residency Training at Brigham and Women's Hospital.

3. Since 2022, I have worked for CDPH as the Assistant Public Health Officer for the State of California. Prior to this position, from 2017-2022, I was the Assistant Health Officer at the San Francisco Department of Public Health, where I supported chronic disease and cancer prevention efforts for the City and County of San Francisco. Prior to that, I was an Assistant Clinical Professor at UCSF with a focus on nutrition security, public health, and providing clinical care to hospitalized patients.

My Role with CDPH

4. I am currently employed by the California Department of Public Health (CDPH) as the Assistant Public Health Officer for the State of California. I oversee CDPH's Population Health Pillar which entails providing policy, program, and administrative oversight of the Centers for Healthy Communities, Family Health, and Environmental Health; the Vital Records and Statistics Division; and the Office of Data Strategy. The Maternal Child and Adolescent Health Program, which houses the Black Infant Health Program, is located under the Center for Family Health, which I oversee. As the Assistant Public Health Officer, I also assist and support the Director and State Public Health Officer with pressing and/or emerging public health issues.

Health Equity Issues Facing Californians

5. Over the past few decades, California has seen improvements in overall health, with longer life expectancy and declines in death rates for several chronic conditions, including ischemic heart disease, stroke, lung cancer, chronic obstructive pulmonary disease (COPD), prostate cancer, and breast cancer. California also has one of the lowest all-cause mortality rates and the highest life expectancy in the nation thanks to the successes of public health, healthcare, and improved access to resources that promote good health, like education and nutrition supports. Life expectancy, all-cause mortality, and the infant mortality rate all worsened during the pandemic, but have now recovered to pre-pandemic levels. Since 2000, death rates have declined for all age groups except younger adults.[1]

6. Despite important gains in health outcomes, notable disparities persist between demographic groups, including those defined by race and ethnicity, region, gender, education level, and income. Disparities in mortality rates are evident from early life stages and continue throughout the lifespan, particularly among Black or African American, Native Hawaiian and Pacific Islander, and American Indian and Alaska Native populations. Californians living in rural areas experience higher mortality rates compared to populations within urban areas. This pattern is observed for many specific causes of death, including road injury, suicide, and drug overdose. Unequal access to the social drivers of health such as wealth, education, and healthcare access are closely linked to community health outcomes.[2]

Epidemiological Data

7. Epidemiologic data are collected and analyzed to understand the frequencies, patterns, and drivers of health-related outcomes in populations, organized by time, place, and person. Analyses include descriptive methods (who,

[1] California State of Public Health Report, 2026. Sacramento, CA: California Department of Public Health; 2026. https://www.cdph.ca.gov/Programs/OPP/CDPH%20Document%20Library/California-State-of-Public-Health-Report-2026.pdf.

[2] *Id*.

what, where, when) to identify patterns and inferential methods (why/how) to test hypotheses regarding disease causes.

8. Many data sources are used by CDPH to assess Californians' health, including vital statistics (i.e., births and deaths), surveillance systems and registries (e.g., reportable communicable/infectious diseases case and lab reporting systems, cancer registry), hospital discharge and emergency department visit data, administrative data, surveys, socioeconomic-related data, and more.[3]

The CDPH Maternal, Child, & Adolescent Health (MCAH) Division

9. Under CDPH, the Maternal, Child and Adolescent Health (MCAH) Division administers public funds to local partners to promote the health of women of reproductive age, pregnant people, mothers, infants, children, and adolescents in California. MCAH administers funds to Local Health Jurisdictions and Community Based Organizations through contracts and/or allocation agreements. MCAH provides health information, data dashboards, and programs to help promote the physical, emotional, mental, and social health of California mothers, birthing people, babies, children, and youth. MCAH's intent is to ensure that all pregnant people and their children can obtain quality maternal and child health services in the State of California.

10. MCAH is staffed by a multi-disciplinary team of experts, including doctors, nurses, social workers, epidemiologists, data analysts, scientists and various public health professionals.

11. As part of its public health mission, MCAH analyzes population-based data—including vital records (births, deaths, and fetal deaths), hospital records (emergency department, inpatient, and outpatient), and population-representative surveys—to measure, track, and highlight health disparities among California families. These analyses are conducted by MCAH scientific staff and inform

[3] *Id.*

MCAH's strategic planning and programmatic decisions, including resource allocation. Results are made publicly available through MCAH Data Dashboards.[4]

12. MCAH publishes the online interactive Data Dashboards for California designed with input from MCAH scientists, program staff, communications staff, the MCAH leadership team, and local MCAH directors. Decisions as to what data are shown on each dashboard are based on data availability and relevance to MCAH outcome and performance measures. The dashboards provide state, county, and/or regional-level data shown by various stratifications or subgroups by year. The dashboard content is regularly updated and supplemented.

13. MCAH Data Dashboards are based on many population-level data sources, including, but not limited to, vital statistics (i.e., birth, death, birth cohort), hospitalizations, the Maternal and Infant Health Assessment (MIHA) and the California Pregnancy Mortality Surveillance System (CA-PMSS). Research scientists in the MCAH Division compile, analyze, and report the data.

14. MCAH Data Dashboards present as much information on race and/or ethnicity as possible, including data on people reporting multiple categories. Most dashboards show the following categories: American Indian or Alaska Native, Asian, Black, Hispanic, Native Hawaiian or Pacific Islander, White, and Multiracial. Some race categories are further disaggregated into subgroups (e.g., Asian). Disparities are also monitored by additional demographic categories such as education, neighborhood poverty, insurance status, health care access, and geographic area, data source permitting.

[4] California Department of Public Health, Maternal, Child and Adolescent Health Division, MCAH Data Dashboards, Sacramento, CA. Available at: https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/default.aspx#backtoTop (last visited May 5, 2026).

How Statistical Data and Studies are Used by CDPH and MCAH to Develop Programming

15. CDPH's programming decisions are data driven and resource conscious. CDPH uses epidemiologic data to identify the populations and geographic areas where public health interventions will have the greatest impact. This targeting operates at both the geographic and demographic level: where data indicate an elevated health burden in a particular county or among a particular demographic group, resources are allocated accordingly.

16. In addition, because studies have demonstrated that racism, social and economic stressors, and neighborhood conditions, among other factors, contribute to poor birth outcomes for Black pregnant and post-partum people and infants, MCAH has designed or funded programming specifically to address these disparate outcomes.[5]

Racial Disparities Evidenced By the Data

Racial Disparities in Infant Mortality, Preterm Birth, and Low Birth Rate

17. MCAH data brings to light persistent racial disparities in infant health outcomes in California. Black infants in California die at disproportionately high

[5] J.L. Alhusen, K.M. Bower, E. Epstein, P. Sharps, *Racial Discrimination and Adverse Birth Outcomes: An Integrative Review* 61 (6) J. Midwifery Women's Health 707–720 (Nov. 2016); A.T. Geronimus, M. Hicken, D. Keene, J. Bound, *"Weathering" and Age Patterns of Allostatic Load Scores Among Blacks and Whites in the United States* 96 (5) Am. J. Public Health 826–833 (May 2006); A.T. Forde, D.M. Crookes, S.F Suglia, R.T. Demmer, *The Weathering Hypothesis as an Explanation for Racial Disparities in Health: a Systematic Review* 33 Ann. Epidemiol. 1–18 (May 2019); K. Kennedy-Moulton, S. Miller, P. Persson, M. Rossin-Slater, L. Wherry, G. Aldana, *Maternal and Infant Health Inequality: New Evidence from Linked Administrative Data,* NBER Working Paper No. 30693, JEL No. I1, I14, I30 (Nov. 2022, Rev. Oct. 2025); K.C. Schoendorf, C.J. Hogue, J.C. Kleinman, D. Rowley, *Mortality Among Infantsof Black as Compared with White College-Educated Parents* 326 (23) N. Engl. J. Med. 1522–26 (Jun. 4, 1992); I.Z. Smith, K.L. Bentley-Edwards, S. El-Amin, W. Darity, Jr., *Fighting at Birth: Eradicating the Black-White Infant Mortality Gap*, Duke University's Samuel DuBois Cook Center on Social Equity and Insight Center for Community Economic Development, (2018); *Centering Black Mothers in California: Insights Into Racism, Health, and Well-Being for Black Women and Infants*, Sacramento, CA: California Department of Public Health, Maternal, Child, and Adolescent Health Division (2023).

rates. Although the Black infant mortality rate declined 25% since 2000, in 2023 it remained 3 times higher than the White and Asian rates (8.75 vs. 2.90 and 2.60 deaths per 1,000 live births, respectively), and 2 times higher than the Hispanic rate (4.21).[6]

18. Preterm birth (PTB) and low birth weight (LBW) reflect the same pattern. In 2024, the PTB rate among Black infants (12.85%) was nearly double the White rate (7.73%), and the LBW rate among Black infants (12.69%) was more than double the White rate (5.84%).[7]

Racial Disparities in Pregnancy-Related Mortality

19. The overall pregnancy-related mortality rate in California declined to 12.0 deaths per 100,000 live births in 2023, down from 21.6 in 2021 and 18.6 in 2020 during the COVID-19 peak. Nonetheless, the Black birthing population bears a disproportionate burden: averaged over 2021–2023, the pregnancy-related mortality rate among Black birthing individuals was 57.8 per 100,000 live births—3.6 times the White rate (15.9), 4.0 times the Hispanic rate (14.3), and 4.3 times the Asian rate (13.3). Severe Maternal Morbidity and hypertension at delivery follow the same pattern. In 2024, the SMM rate among Black birthing individuals was 185.9 events per 10,000 delivery hospitalizations, 76% higher than the White rate of 105.6. In 2023, the prevalence of hypertension at delivery among Black birthing individuals (19.3%) was 33% higher than among White birthing individuals (14.5%).[8] Preventable death of mothers, birthing people, and infants have long-reaching impacts on the health of affected families and communities.

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[6] California Department of Public Health. Center for Family Health, Maternal, Child and Adolescent Health Division, Infant Mortality Dashboard, Last Modified April 2026.

[7] California Department of Public Health. Center for Family Health, Maternal, Child and Adolescent Health Division, Preterm Birth Dahsboard, Low Birthweight Dashboard, Last Modified April 2026.

[8] California Department of Public Health. Center for Family Health, Maternal, Child and Adolescent Health Division, Pregnancy Related Mortality Dashboard, Severe Maternal Morbidity Dashboard, Maternal Health Conditions at Delivery Dashboard, Last Modified March 2026.

Racism, Weathering, and Accelerated Biological Aging

20. Racism functions as a chronic physiological stressor with biological consequences, contributing to hypertension, diabetes, obesity, preterm birth, and severe maternal outcomes.[9] Among Black women in California with a recent birth, chronic worry about interpersonal racism more than doubled between 2011 and 2019, rising from 26.6% to 56.2%.[10] By 2020–2022, 71% of Black women reported worrying about racism for themselves or a loved one, and 42% reported direct lifetime experiences of interpersonal racism.[11]

21. Peer-reviewed research demonstrates that Black women experience accelerated biological aging—termed "weathering"—as a result of cumulative, race-based physiological stress.[12] This phenomenon is measurable through elevated allostatic load scores and shortened telomere length, both associated with increased mortality, cardiovascular disease, diabetes, and other serious conditions.[13] A 2006 national study found that both poor and non-poor Black

[9] W.L. Macias-Konstantopoulos, K.A. Collins, R. Diaz, H.C. Duber, C.D. Edwards, A.P. Hsu, M.S. Ranney, R.J. Riviello, Z.S. Wettstein, C.J. Sachs, *Race, Healthcare, and Health Disparities: A Critical Review and Recommendations for Advancing Health Equity* 24 (5) West J. Emerg. Med. 906–918 (Sept. 2023); E.M. Hailu, S.R. Maddali, J.M. Snowden, S.L. Carmichael, M.S. Mujahid, *Structural Racism and Adverse Maternal Health Outcomes: A Systematic Review* 78 Health Place. 102923 (Nov. 2022).

[10] See *Centering Black Mothers in California: Insights into Racism, Health, and Well-being for Black Women and Infants*, *supra* note 5.

[11] California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, 2025, https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-Snapshots-Dashboard.aspx (last visited May 5th, 2026).

[12] M.E. Levine, E.M. Crimmins, *Evidence of Accelerated Aging Among African Americans and its Implications for Mortality*, 118 Soc Sci Med 27-32 (Oct. 2014); A.T. Geronimus, M.T. Hicken, J.A. Pearson, S.J. Seashols, K.L. Brown, T.D. Cruz, *Do US Black Women Experience Stress-Related Accelerated Biological Aging?: A Novel Theory and First Population-Based Test of Black-White Differences in Telomere Length* 21(1) Hum. Nat. 19–38 (Mar. 10, 2010); see Geronimus, et al., *supra* note 5; see Forde, et al., *supra* note 5.

[13] E.J. Rodriquez, E.N. Kim, A.E. Sumner, A.M. Nápoles, E.J. Pérez-Stable, *Allostatic Load: Importance, Markers, and Score Determination in Minority and Disparity Populations* 96 (Supp. 1) J. Urban Health 3–11 (Mar. 2019); B. McEwen, P. Nasveld, M. Palmer, R. Anderson, *Allostatic Load: A Review of the Literature*, 2012, Canberra, Australia: Department of Veterans' Affairs; C.V. Schneider, K.M. Schneider, A. Teumer, et al., *Association of Telomere Length With Risk of Disease and Mortality* 182 (3) JAMA Intern. Med. 291–300 (2022).

women ranked highest in allostatic load scores compared to White women and men at equivalent socioeconomic levels. Researchers attribute this disparity to cumulative lifetime exposure to race-based stressors—not to socioeconomic factors.[14] A recently published study synthesized evidence on the detailed physiological pathways through which the impacts of systemic racism, socioeconomic disadvantage, and environmental stressors on Black women can translate into disparities in maternal and infant health outcomes when compared to White women.[15]

Structural and Environmental Conditions

22. Residential segregation further concentrates Black women in under-resourced environments. In California, 77% of Black women reside in less privileged neighborhoods, compared to 32% of White women, while only 8% reside in the most privileged neighborhoods, compared to 36% of White women.[16] These conditions restrict access to stable housing, nutritious food, economic stability, and other health-promoting resources that directly affect maternal and infant health outcomes.

Disparities Persist Across Socioeconomic Status Categories

23. Neither higher income nor higher educational attainment eliminates these health disparities for Black women. Many studies examining maternal and infant health outcomes have adjusted for these factors and shown that disparities persist. In the United States, even well-educated, high-income Black mothers and their infants experience health outcomes similar or worse than White women who are more economically disadvantaged.[17]

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[14] See Geronimus, et al., *supra* note 5.

[15] G.E.A. Amedor, D.A. Giussani, *Physiological Mechanisms Mediating Socio-Environmental Influences on Pregnancy Outcomes in Black People*, 10 Trends in Endocrinology & Metabolism 1016 (Mar. 2026).

[16] See *Centering Black Mothers in California: Insights into Racism, Health, and Well-being for Black Women and Infants*, *supra* note 5.

[17] W.D. Barfield, *Social Disadvantage and its Effect on Maternal and Newborn Health*, 45(4) Semin. Perinatol. 151407 (Jun. 2021).

24. A national study using linked data for the period 2007-2010 found that while infant mortality rates were similar for Mexican Americans and Whites regardless of differences in educational attainment of mothers, infants of college-educated Black women experienced 3.1 more deaths per 1,000 live births than infants of White women with a high school degree or less. Another study found that infants born to Black women with doctoral and professional degrees were found to have more than double the rate of death within their first year compared to White women who never finished high school.[18]

25. A study using data from California for the period 2007-2016 found that infants born to Black mothers have the worst outcomes at all points in the income distribution. Rates of preterm birth rate ranged from 11.7 % to 14.9% and rates of low birthweight ranged from 11.2% to 14.3% for this group. In contrast, rates of preterm birth ranged from 8.2% to 11.4% and low birthweight rates ranged from 6.3 % to 8.8 % for infants born to White mothers.[19]

26. A national study using data for live births in the United States for the period 2015-2017 that included only births among women with private insurance found that racial disparities in prematurity persist even among this group. Rates of preterm birth (less than 37 weeks gestation) remained highest for women who identified as Black, intermediate for women identifying as both Black and White race, and lowest for White women (9.9% vs. 6.1% vs. 5.5%, respectively).[20]

27. Regarding pregnancy-related mortality, in the United States, Black women with a college education have higher rates of pregnancy-related mortality

[18] D. Hamilton, *Post-Racial Rhetoric, Racial Health Disparities, and Health Disparity Consequences of Stigma, Stress, and Racism*, Washington Center for Equitable Growth (2017).

[19] See Kennedy-Moulton, et al., *supra* note 5.

[20] J.D. Johnson, C.A. Green, C.J. Vladutiu, T.A. Manuck, *Racial Disparities in Prematurity Persist Among Women of High Socioeconomic Status*, 2 Am. J. Obst. Gynec. 100104 (2020).

(40.2 pregnancy-related deaths per 100,000 live births) than White women with less than a high school degree (25.0 pregnancy-related deaths per 100,000 live births).[21]

28. These patterns have been observed for key health conditions that are drivers for adverse maternal and infant health outcomes. For example, even at higher incomes (200% federal poverty level or higher), Black people are more likely to suffer from a chronic condition or disability (45% of Black adults ages 19-64) than whites (32%) and Hispanics (23%).[22] Significant Black:White disparities exist with regard to both pre-pregnancy and maternal hypertension and asthma rates for Black women.[23] Chronic hypertension (diagnosed before pregnancy or up to 20 weeks gestation) or gestational hypertension (diagnosed after 20 weeks gestation) is associated with increased risk of maternal complications such as preeclampsia, gestational diabetes, placental abruption, and poor birth outcomes such as preterm delivery, low birth weight, and perinatal mortality.[24]

Discrimination in Maternity Care

29. Black women experience discrimination in maternity care at rates exceeding all other groups. A 2023 nationwide survey found that 40.1% of Black respondents experienced at least one form of discrimination during maternity care—the highest prevalence of any racial or ethnic group surveyed, compared to an overall rate of 28.9%.[25] A concurrent California survey found that only 54.6%

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[21] E.E. Petersen, N.L. Davis, D. Goodman, D. S. Cox, C. Syverson, K. Seed, C. Shapiro-Mendoza, W.M. Callaghan, W. Barfield, *Racial/Ethnic Disparities in Pregnancy-Related Deaths - United States, 2007-2016*, 68 (35) MMWR Morb. Mortal. Wkly. Rep. 762–765 (Sept. 6, 2019).

[22] H. Mead, L. Cartwright-Smith, K. Jones, C. Ramos, B. Siegel, K. Woods, *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook*, The Commonwealth Fund. Pub. No. 111, (2008).

[23] See *Centering Black Mothers in California: Insights into Racism, Health, and Well-being for Black Women and Infants*, *supra* note 5.

[24] A.B. Wallis, A.F. Saftlas, J. Hsia, H.K. Atrash, *Secular Trends in the Rates of Preeclampsia, Eclampsia, and Gestational Hypertension, United States, 1987–2004*, 21 (5) Am. J. of Hypertension 521–526 (2008); ACOG Practice Bulletin No. 203, *Chronic Hypertension in Pregnancy* 133 (1) Obst. & Gynec. e26–e50 (2019).

[25] Y.A. Mohamoud, E. Cassidy, E. Fuchs, et al., *Vital Signs: Maternity Care Experiences—United States, April 2023*, 72 MMWR Morb. Mortal. Wkly. Rep. 961–967 (2023).

of Black women received optimal care during delivery, compared to 63.2% of women overall.[26] Qualitative research further documents that Black women in California routinely describe their maternity care as disrespectful and stressful.[27]

MCAH's Programmatic Response to These Health Outcome Disparities

30. The disparities documented above constitute the scientific and epidemiologic basis for MCAH's targeted programmatic investments in Black maternal and infant health. MCAH programs established to investigate and address these disparities include the Black Infant Health (BIH) Program and the Perinatal Equity Initiative. California's "Momnibus" Act (SB 65, 2021) further codified this commitment by requiring CDPH to establish the California Pregnancy-Associated Mortality Review Committee (CA-PARC), effective August 1, 2022, to review pregnancy-related deaths, analyze causes of severe maternal morbidity, and recommend prevention strategies—with explicit focus on racial and socioeconomic disparities in maternal health.

The Black Infant Health (BIH) Program

History of the BIH Program

31. CDPH MCAH Division places a high priority on addressing poor birth outcomes that disproportionately impact the Black community. In 1989, with the passage of Senate Bill 165, Budget Act of 1989, California began to more aggressively address the challenge of improving the health of Black women, infants, and children by promoting health and health care during the prenatal and post-partum periods and providing services in a supportive and culturally supportive manner. Originally a pilot project at four sites, the BIH Program

[26] *Improving Black Maternal Health Through Person-Centered Care, San Francisco, CA*: UCSF Center for Health Equity (CHE), 2025, https://healthequity.ucsf.edu/mce Enhancing Black Maternal Health in California: The Role of Person-Centered Maternity Care

[27] M.R. McLemore, M.R. Altman, N. Cooper, S. Williams, L. Rand, L. Franck, *Health Care Experiences of Pregnant, Birthing and Postnatal Women of Color at Risk for Preterm Birth*, 201 Soc. Sci. Med. 127–135, (Mar. 2018).

expanded to reach 17 local health jurisdictions where over 90 percent of all Black births occur in California.

32. In 2006, CDPH/MCAH commissioned the University of California, San Francisco Center on Social Disparities in Health (UCSF/CSDH) to conduct an assessment of the BIH Program and to provide a scientific basis for recommending interventions, informed by the expertise of local BIH program staff and a statewide BIH Community Advisory Board. The assessment report found that, given the complex and multifaceted root causes of adverse Black maternal and infant health outcomes, there was no evidence to support any singular, specific, short-term solution to reduce adverse pregnancy and birth outcomes among Black women.[28] Known causes of poor pregnancy and birth outcomes in the overall population do not fully explain Black:White disparities; these include inadequate prenatal care, limited maternal education, substance use, chronic medical conditions, and disadvantaged neighborhood conditions.[29] Current scientific evidence suggests the health of Black families could be improved through a social support and empowerment-based approach focused on building resilience, managing and reducing experiences of stress, the provision of health education and referrals to needed services, and leveraging community assets for change.[30] There is consensus

[28] P. Braveman, G. Nicholson, K. Marchi, *The Black Infant Health Program: Comprehensive Assessment Report and Recommendations*, University of California, (2008).

[29] P. Braveman, T. P. Dominguez, W. Burke, S.M. Dolan, D.K. Stevenson, F.M. Jackson, J.W. Collins, Jr., D.A. Driscoll, T. Haley, J. Acker, G.M. Shaw, E.R.B. McCabe, W.W. Hay, Jr, K. Thornburg, D. Acevedo-Garcia, J.F. Cordero, P.H. Wise, G. Legaz, K. Rashied-Henry, J. Frost, L. Waddell, *Explaining the Black-White Disparity in Preterm Birth: A Consensus Statement From a Multi-Disciplinary Scientific Work Group Convened by the March of Dimes*, 3 Frontiers in Repr. Health 684207 (2021).

[30] F. Wakeel, L.E. Wisk, R. Gee, S.M. Chao, W.P. Witt, *The Balance Between Stress and Personal Capital During Pregnancy and the Relationship with Adverse Obstetric Outcomes: Findings From the 2007 Los Angeles Mommy and Baby (LAMB) Study*, 16(6) Arch. Women's Ment. Health 435–451, (2013); Z. Massey, S.S. Rising, J. Ickovics, *Centering Pregnancy Group Prenatal Care: Promoting Relationship-Centered Care*, 35(2) J. Obst. Gynec. & Neonat. Nursing 286–294, (2006); P.A. Thoits, *Personal Agency in the Stress Process*, J. Health & Soc. Behav. 309–323, (2006); P.A. Thoits, *Mechanisms Linking Social Ties and* (continued…)

that Black:White disparities in maternal and infant health must be addressed at multiple levels (a multipronged approach), including direct services like BIH, together with medical interventions, policies, and community-based efforts.

33. Throughout the process of growing and expanding the BIH Program, between 2006 and 2015, expertise from various sources such as local BIH Program administrative and direct-service staff, UCSF/CSDH, and nationally recognized leaders in maternal and infant health collaborated to create a single core model with the goal of developing a program that is both evidence-based and feasible in terms of its accessibility and acceptability for BIH Program participants.

34. Over a three-year period, more than 100 people, most of them from local BIH Programs, participated in the process. The BIH Program focuses on improving a set of health and health-related outcomes hypothesized to be in the pathway to birth outcomes, reflecting current scientific knowledge about the individual and community-level factors that influence health and health disparities.[31] Building on successful components of existing BIH Program models and incorporating other promising practices, the resulting model includes client-centered social services that integrate prenatal, postpartum, parenting and infant-health education and promotion with program pillars of social support, stress reduction, and empowerment.

35. To better meet the health-related needs of pregnant and postpartum Black women and birthing people who are the target population for the BIH Program, in 2011, CDPH/MCAH began implementing a standardized BIH Program that features both: (1) a group intervention designed to encourage empowerment and social support while promoting healthy behaviors, and (2) one-to-one support to

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Support to Physical and Mental Health, 52(2) J. Health & Soc. Behav. 145–161, (2011); B.N. Uchino, *Social Support and Health: A Review of Physiological Processes Potentially Underlying Links to Disease Outcomes*, 29(4) J. Behav. Med. 377–387, (2006).

[31] See Braverman, *supra* note 29; 2015-2018 Black Infant Health Program Evaluation: Intermediate Outcomes Among Prenatal Group Model Participants. https://www.cdph.ca.gov/Programs/CFH/DMCAH/BIH/Pages/Data-Brief-Intermediate-Outcomes-2015-2018.aspx; see Smith, et al., *supra* note 5.

link participants with needed community and health-related services. This program thus provides services in a culturally relevant manner that respects participants' beliefs and cultural values while promoting overall health and wellness, recognizing that women's health and health-related behaviors are shaped by non-medical factors (e.g., the effects of stress related to limited social and economic resources as well as racism and discrimination).[32] The BIH Program has been developed to address these social determinants of health in ways that are relevant, culturally affirming, and empowering to participants. The Program also offers one-to-one support for pregnant and postpartum Participants who are unable to attend group sessions.

36. In other words, the BIH Program is designed to address a public-health crisis: the significantly disproportionate risk of adverse maternal and infant-health outcomes for Black women. As detailed earlier, Black babies, historically, have had higher rates of infant mortality, low birth weight, and prematurity than any other ethnic group.[33] Additionally, studies show that Black women at all income and education levels experience worse birth outcomes, including pregnancy and birth-related complications and death than White women.[34]

37. Multiple decades of research has made clear that simply increasing access to prenatal care is not "the cure" for Black infant and maternal mortality. Risk factors prevail at multiple levels starting upstream through systemic/structural racism, then midstream with unfair treatment/discrimination (economic disadvantage, mass incarceration, disenfranchisement), and downstream through health harming exposures (chronic stress, inadequate medical care) that ultimately influence biological mechanisms (immune function, inflammation, allostatic load),

[32] See Alhusen, et al., *supra* note 5; see Smith, et al., *supra* note 5.

[33] California Department of Public Health. Center for Family Health, Maternal, Child and Adolescent Health Division, Infant Mortality Dashboard, Last Modified April 2026.

[34] See Kennedy-Moulton, et al., *supra* note 5; see also Smith, et al., *supra* note 5.

creating a "perfect storm" that causes significantly worse infant and maternal-health outcomes in the Black community compared to other communities.[35]

38. Through the Department's implementation of the BIH program model discussed above, culturally specific interventions can provide critical support that participants can utilize to remain physically and mentally well during pregnancy, postpartum, and beyond, and ultimately contribute to improving adverse outcomes. Results of the most recent evaluation of the program support BIH as a promising strategy to improve the health of Black birthing people and their families. Participants in the BIH prenatal group model showed significant positive change in several intermediate health and health-related outcomes, including social support, empowerment, stress management, reduction of depressive symptoms, health knowledge (such as safe sleep practices) and behaviors (such as reduction in smoking).[36] These positive outcomes align with the MCAH Division's goals described in the State Action Plan to see reductions in negative health outcomes for Black birthing women and Black infants by 2030.

Governing Concepts of the BIH Program

39. All aspects of the BIH Program have been developed with attention to four key governing concepts:

- Services are provided in a culturally relevant manner. This means the program provides care to people in a manner that accounts for their unique values, beliefs and behaviors, tailoring delivery to meet participants' social, cultural, and linguistic needs.
- The Program presents a client-centered approach. The client-centered approach focuses on developing goals and strategies that are personalized and realistic and is conducted in an interactive manner that encourages

[35] See Braveman, et al., *supra* note 29; see Amedor, et al., *supra* note 15.
[36] See 2015-2018 Black Infant Health Program Evaluation: Intermediate Outcomes Among Prenatal Group Model Participants, *supra* note 31.

participants to do most of the work, which empowers participants to take full responsibility for their lives.

- A strength-based approach is utilized to empower and support self-sufficiency. Health and mental health fields have long histories of focusing on deficits, problem behaviors, and pathologies. Within the last decade, researchers, clinicians and practitioners have begun to question the deficit-based approach and are moving toward a strength-based approach, which is a collaborative process that acknowledges that we all have untapped or unrecognized strengths.[37] These strengths can be accessed and used to foster growth and healthy behavior change.
- The program supports cognitive skill-building that supports empowerment and the belief that participants are capable of change. Cognitive behavioral therapy (CBT) is utilized and is an approach that aims to solve problems through a goal-oriented process, embracing the concepts that behaviors are learned and that participants can learn how to think differently and act on what they have learned. Participants' success is measured by improved quality of life and well-being.

Impact of the BIH Program

40. Pregnant women and birthing people who enroll in the BIH Program receive basic assistance, such as diapers and baby items, transportation assistance to and from doctor appointments, and also more culturally relevant services. Enrollees participate in group-based intervention, including 10 weekly group sessions during pregnancy and 10 weekly postpartum group sessions with other new mothers and birthing people. Participants also work individually with BIH Program staff in a structured life-planning process designed to complement and

[37] M.B. Snyder, C.M. Pacheco, L. Mische-Lawson, *Integrating Social Drivers of Health With Strengths-Based Approaches in Clinical Care*, AJPM Focus, https://doi.org/10.1016/j.focus.2025.100466 (last visited May 5, 2026).

reinforce their group experiences. All group facilitators are trained by CDPH and MCAH.

41. The group-based program sessions are designed to provide participants with a culturally affirming environment that honors the unique history of Black women in order to help participants enhance life skills, learn strategies for reducing stress, and build social support. The BIH Program specifically targets racial and socioeconomic disparities in maternal health, recognizing through data-driven research that access to care, resources, and support are not equal for all mothers.

BIH Program Sites

42. The BIH Program is run through city and county Local Health Jurisdictions (LHJs) as part of their Maternal, Child and Adolescent Health divisions. Several LHJs have elected to subcontract with community-based organizations to provide services. Each service area has a requisite minimum number of qualified personnel, including a coordinator, family health advocates, group facilitators, outreach liaison, a mental health professional and a public health nurse. All sites follow the CDPH and MCAH policies and procedures to ensure standardization across all sites, which includes ten 150-minute in-person prenatal and postpartum group sessions, individualized life planning, referrals to pertinent services, and outreach efforts to educate the community at-large about these persisting disparities.

Enrollment in the BIH Program

43. Although the Program is geared towards addressing the needs of the self-identifying Black and African-American population, who otherwise fall within gestational and postpartum timing parameters, if a prospective participant who local BIH Program staff believe would benefit from participation in the program does not identify as Black, local BIH staff can facilitate the person's admission.

44. CDPH elected to focus on culturally specific interventions to provide critical supports that participants can utilize to remain physically and mentally well

during pregnancy, postpartum, and beyond, and ultimately contribute to improving adverse outcomes. The BIH program model and approach is supported by numerous studies showing the effectiveness of culturally-appropriate maternity care services and group perinatal services with peer support in terms of improving birth outcomes.[38] Enrolling participants that identify as Black or African-American aligns participants' racial backgrounds for shared lived experience and encourages inter-personal trust within the groups. The BIH program would not be as successful at targeting the disparity in infant mortality and health outcomes in the Black community were it, as compared to other available programs, not to encourage the enrollment of participants that self-identify as Black or African-American.

Non-Black/African American Participants in the BIH Program

45. I have reviewed the BIH Policies and Procedures Manual referenced in our agreements with local BIH implementing agencies and have verified our program administrative processes with our BIH Program Lead, and I am not aware of any specific individuals who have been excluded from the program or BIH services on the basis of race.

46. CDPH does not take any actions to enforce any policies that might be interpreted to suggest that local BIH sites should disallow individuals from entering the program, or require individuals to be disenrolled from the program, based on racial criteria.

[38] C. Klima, K. Norr, S. Vonderheid, A. Handler, *Introduction of Centering Pregnancy in a Public Health Clinic*, 54 (1) J. Midwifery Womens Health 27–34, (Jan.-Feb. 2009); J.R. Ickovics, V. Earnshaw, J.B. Lewis, et al., *Cluster Randomized Controlled Trial of Group Prenatal Care: Perinatal Outcomes Among Adolescents in New York City Health Centers*, 106 (2) Am. J. Public Health 359–365, (2016); *CenteringPregnancy and CenteringParenting*, Annotated Bibliography, Centering Healthcare Institute, (2025); M. Alsan, O. Garrick, G. Graziani, *Does Diversity Matter for Health? Experimental Evidence From Oakland*, 109 (12) C. Am. Econ. Rev. 4071–4111 (2019); C. Klima, K. Norr, S. Vonderheid, A. Handler, *Introduction of CenteringPregnancy in a Public Health Clinic*, 54 (1) J. Midwifery Womens Health 27–34, (2009); E. Jones, S.R. Lattof, E. Coast, *Interventions to Provide Culturally-Appropriate Maternity Care Services: Factors Affecting Implementation*, 17 BMC Pregnancy Childbirth 267 (2017).

47. CDPH also does not have any quality control measures, or reporting or review processes that would require, or even encourage, local BIH sites to not admit or to disenroll individuals from the program based on racial criteria.

48. CDPH provides a recruitment form to local BIH sites—the BIH Recruitment Form—to be used when recruiting possible program participants. The Form is intended for the intake of prospective BIH participants, whether they are referred by another provider or another agency, or whether they have been identified through direct BIH staff outreach, media outreach, or self-referral to the program. This form does not include any language requesting the prospective participant's race or contain any boxes to record the potential participant's race. Attached hereto as **Exhibit A** is a true and correct copy of the BIH Recruitment Form.

49. Local BIH sites often consult with CDPH program administrators regarding individuals who do not meet requirements to participate in the program. Local sites have reached out to CDPH regarding applicants who were not of the age or gestational condition described in the enrollment procedures, but to whom the local BIH site intended to provide BIH services because the applicant's maternal health and wellness would benefit from the services in a manner that furthered the goals of the BIH program. For example, there have been cases where participants have suffered miscarriages, exceeded 30-weeks gestation, or were more than six months post-partum, and were able to continue receiving BIH services. To my knowledge, there have not been instances where any of our local sites have reached out regarding or otherwise reported to CDPH an instance of an applicant who was going to be disallowed based on the applicant's race, and CDPH staff were unaware of any instances where a local BIH site inquired about denying an applicant based on their race.

50. Using linked data with the California Birth Statistical Master File, CDPH identified that some past participants reported racial classifications on their

California birth records that did not include any reference to Black, but instead identified as: White, American Indian, or another racial category. Beginning in late 2024, the BIH Program began collecting self-identified race ethnicity data from participants after they had already been admitted to the program. These data also show that some participants did not identify as Black, but rather as Hispanic, Asian, White, American Indian or Alaska Native, and Middle Eastern or North African.

51. I am not aware of anyone being turned away, rejected, or disenrolled from the program on the basis of race, including the plaintiff in this case, Erica Jimenez.

52. It is my understanding that if Ms. Jimenez, or any other person who does not self-identify as Black or African American, sought to participate in the program, and local BIH staff believe that she would benefit from participation in the program, local BIH staff can facilitate the person's admission regardless of their self-identified race.

Other Programs and Resources Through MCAH

53. MCAH's overriding mission to provide health information, data, and programs means that other programmatic options, including culturally sensitive programs, are available to women and birthing persons and their infants who do not qualify for or are not interested in participation in the BIH. Each MCAH program is also expected to ensure the availability of a toll-free or "no cost to the calling party" telephone system that provides a current list of culturally and linguistically appropriate information and referrals to community-health and human resources for the public regarding access to prenatal care.

54. These other programs include:

- Local Maternal, Child and Adolescent Health Program: Local county and city Maternal, Child and Adolescent Health (MCAH) departments are responsible for improving the health and well-being of the women and families in their region. This is done through an array of programs

and initiatives that serve California's diverse populations, providing best practice interventions, resources, information and data about health and social topics such as reproductive health, family planning, pregnancy, intimate partner violence and more. The initiatives provided vary by Local Health Department.

- California Home Visiting Program (CHVP) Programs:
  - Family Connects: Supports health for all families with newborns at a moment of life-changing transition. Trained Family Connects nurses offer home visits to assess the needs of newborns and postpartum parents, provide health information and refer to community and medical services when needed.
  - Healthy Families America: Serves low-income families who must be enrolled within the first three months after an infant's birth. A trained paraprofessional provides home visits to parents and their children through three years of age.
  - Home Instruction for Parents of Preschool Youngsters: Serves families with children between the ages of two and five. Offers parents support, training and material to engage in effective, developmental and fun activities with their children in the comfort of their own homes. Program is a developmentally appropriate, early literacy curriculum designed to promote children's cognitive, social, emotional and physical development. Parents engage with the curriculum by roleplaying the parent-child activities with a home visitor who is from the same community.
  - Nurse-Family Partnership: Serves low-income, first-time moms who must be enrolled by the 28th week of pregnancy. A Public

Health Nurse provides one-on-one home visits to parents and their babies through two years postpartum.

- Parents as Teachers: Serves families with children (between pregnancy and Kindergarten entry) experiencing one or more stressors in their lives. A Parent Educator conducts personal visits with parents and their children, as well as monthly group events.

55. These programs offer similar services and supports to improve maternal, infant, and/or child-health outcomes and are available to people who meet the eligibility requirements for them. Specific services include referrals to resources, nurse home visiting, and provision of necessary resources to participants.

56. As part of the governing rules and requirements for implementation of the BIH Policies and Procedures, there are policies and procedures that guide staff actions at the local level of a MCAH program if a prospective program participant, like Ms. Jimenez, either is deemed to not qualify for or does not wish to participate in a particular program. In such a case, the prospective participant would be directed to other programs and resources available to her through MCAH or in the surrounding community that would provide similar or overlapping types of resources and supports.

57. For example, in this case, Ms. Jimenez could qualify to participate in, as alternatives to the BIH, the California Home Visitation programs or other Local MCAH programs, assuming she meets their respective eligibility criteria and that she takes the required steps to apply to them.

Conclusion

58. Black women and infants in California experience severe, persistent, and well-documented disparities in maternal and infant health. These disparities, and the scientific literature explaining their root causes, provide the factual and

scientific foundation for programs specifically designed to serve and support Black mothers and birthing people and their infants, including the Black Infant Health program.

59. California faces a significant maternal health crisis among Black women who are disproportionately affected by pregnancy-related deaths. Additionally, there are severe and persistent racial disparities in infant health outcomes in California. Combined, Black maternal and infant health is a significant health-policy issue, driven by a compelling need.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed in Sacramento, California on May 6, 2026.

By: 

Rita Nguyen, M.D.

Exhibit A

Recruitment

Maternal, Child and Adolescent Health Division
Black Infant Health Program
CDPH California Department of Public Health

PARTICIPANT INFORMATION (Add new participant) *Recruitment Date (*Program Start Date*): ____ / ____ / ____

Case Number: _____

*First Name: _____ Middle Name: _____ *Last Name: _____

Preferred Name: _____ *Participant's DOB: _____/_____/_____

Home Address (Address 1): _____ Apt/Ste/Bldg # (Address 2):_____

City: _____ State: _____ *ZIP Code: _____

Mailing Address: _____

City: _____ State: _____ ZIP Code: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Email: _____

What is the best way to contact you? _____

REFERRAL INFORMATION (Recruitment TouchPoint)			
Date Referral Made (*Provider*): _____ / _____ / _____			*BIH Staff Name: _____
*Pregnancy Status:	□ Prenatal	□ Postpartum	*Due Date/Delivery Date: _____/_____/_____
*First time parent?	□ Yes	□ No	□ Unknown
*Referral Source Type (Check primary source):	□ Social Service Provider	□ WIC	□ BIH App/Commercial/PSA/ News article/Press Release
	□ Medical Provider	□ Word of Mouth	□ TV/Radio/Newspaper/ Billboard
	□ County Health Department	□ Other BIH participant	□ Website – blackinfanthealth.org
	□ BIH Staff Outreach- Health fair	□ Returning BIH Participant (previous pregnancy)	□ Internet- other website
	□ BIH Staff Outreach- Street	□ Other: _____	□ Internet- social media, digital ads
For *provider-based referrals*, was the participant information received initially via automated list/report?		□ Yes □ No	PEI provider? □ Yes □ No
Name of Referral Organization (if provider-based referral): _____			
Contact Person: _____			Phone Number: ( ) _____-_____
Name of Referring BIH Staff (if health fair or street outreach): _____			

Dismiss Participant from Recruitment Program (to be completed by BIH Staff)
*Program End Date: _____ / _____ /_____

*Dismissal Reason (CHECK ONE)

Enrolled:	□ Enrolled in BIH Group Model with 1:1 Support	□ Enrolled in 1:1 Support Only
Ineligible/ Not Contacted:	□ Staff unable to contact	□ Not eligible for BIH
Participant Declined:	□ No time available to participate	□ Cannot participate due to transportation, childcare, or other barriers
	□ Not interested	□ Needs could not be met by BIH
	□ Other	

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IN THE UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

ERICA JIMENEZ, individually and on behalf of a class of similarly situated individuals,

Plaintiff,

v.

DR. ERICA PAN, in her official capacity as Director of the California Department of Public Health; DR. BARBARA FERRER, in her official capacity as Director of the Los Angeles County Department of Public Health; MANUEL CARMONA, in his official capacity as the Director of Public Health for the Pasadena Public Health Department; LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH; and PASADENA PUBLIC HEALTH DEPARTMENT,

Defendants.

2:26-cv-03500-SPG-SP

DECLARATION OF MCKENZIE SCOTT IN SUPPORT OF OPPOSITION TO MOTION FOR PRELIMINARY INJUNCTION

Judge: The Honorable Sherilyn Peace Garnett
Trial Date:
Action Filed: 4/02/2026

DECLARATION OF MCKENZIE SCOTT

I, McKenzie Scott, declare as follows:

1. I have personal knowledge of the facts stated herein, except those stated upon information and belief and, to those matters, I believe them to be true. If called to testify to the matters herein, I could and would competently do so.

2. This declaration is made in support of Defendants Manuel Carmona, in his official capacity as Director of Public Health for the Pasadena Public Health Department, the Pasadena Public Health Department ("PPHD"), Dr. Erica Pan, California Department of Public Health, Dr. Barbara Ferrer, in her official capacity as Director of Los Angeles Department of Public Health, and Los Angeles County of Public Health's (collectively "Defendants") opposition to Plaintiff Erica Jimenez's motion for preliminary injunction in the action entitled *Erica Jimenez v. Dr. Erica Pan, et al.* in the United States District Court Central District of California, Case No. 2:26-CV-03500-SPG-SP.

3. I am a Community Services Representative II serving as a Community Outreach Liaison for the City of Pasadena Public Health Department ("PPHD") and have worked in this capacity since 2024. As part of my responsibilities, I assist members of the public who are interested in, among a variety of other programs (discussed below), the Black Infant Health ("BIH") Program, a State of California program that is administered by the County of Los Angeles. PPHD is a subcontractor[1] of the County of Los Angeles for purposes of implementing the BIH program.

4. Generally, PPHD would receive referrals for those interested in the BIH Program from the State of California. On or about February 23, 2026, PPHD received a BIH interest form from the State of California, via email. I later learned

[1] California Department of Public Health Website for Black Infant Health Program: https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Fiscal/Medi-Cal-Factor-Table-BIH.aspx

that the interest form was submitted by Plaintiff Erica Jimenez. I placed a telephone call to Ms. Jimenez on February 23, 2026, but she did not answer the call.

5. I am informed that Ms. Jimenez returned my call on February 24, 2026, but because I was attending a work-related training on February 24, 2026, and February 26, 2026, I was unable to make contact with Ms. Jimenez over the telephone until February 27, 2026.

6. On February 27, 2026, I was able to get a hold of Ms. Jimenez on the telephone. The call lasted approximately 9 minutes. During the call, I provided Ms. Jimenez my name, advised that I worked with the Black Infant Health program, and explained that the program supports/empowers pregnant and postpartum mothers that self-identify as African American or Black. I further explained that, as part of the BIH program, there are group sessions with other women who are Black or identify their baby as Black. In addition, I provided Ms. Jimenez with other resources that she would have access to as an alternative, such as the Maternal, Child, and Adolescent Health programs that offer free car seat checks and a safe sleep program.

7. Specifically, a variety of other programs would have also been available to Ms. Jimenez, which includes: Pacific Clinics, Women, Infants & Children ("WIC"), and Happy Mama Healthy Baby Alliance. Each of these programs offers comparable support and services to the BIH program, including mental health services, head start early childcare services, substance use disorder treatment, unhoused support services, employment services, and health navigation services.

8. I informed Ms. Jimenez of these additional resources, as I do for anyone seeking pregnancy/parenting support, including those interested in the BIH program.

9. At no time during the call did I tell Ms. Jimenez she was being denied admission to, or not eligible for, the BIH program, nor did I ask her to

identify her race during this conversation. I also did not discuss with her the availability of an "exception" for her admission to the BIH program, since I was merely providing her information about her various options during this conversation, which, as I explained, did not concern any application by her for admission to the BIH, or any evaluation of her eligibility for same.

10. Indeed, it is neither part of my training nor my practice to inform those interested in the BIH program (or any other program) over the telephone that they are not eligible to participate. In fact, once an applicant is ready to enroll in BIH, the applicant will meet with PPHD's Mental Health Specialist ("MHS") who collects pertinent information and completes initial health assessments. This is usually done in-person or via the telephone. The applicant would then meet with the MHS to complete their enrollment. Once that is completed, the applicant be assigned a Family Health Advocate who will be their main point of contact throughout their time in the program.

11. In my experience as a Community Outreach Liaison for the PPHD, I have no knowledge that we have ever rejected an application for admission to the BIH program on the basis of the race of an otherwise qualified person interested in participating in the program. To the contrary, I am aware of instances in the past in which we have allowed individuals who did not identify as Black or African American to participate in the program because they were interested and otherwise eligible. As a result, upon information and belief, the PPHD does not turn anyone away from the BIH program. PPHD does not reject anyone from the BIH program.

12. The approximate 9-minute call on February 27, 2026 was the only contact I ever had with Ms. Jimenez. Upon information and belief, Ms. Jimenez did not contact PPHD at any time after my call with her on February 27, 2026, to apply for or further explore either admission to the BIH program or the alternative resources and programs to which I referred her.

I declare under penalty of perjury under the laws of the State of California and the United States of America that the foregoing is true and correct.

Executed May 5, 2026, at Pasadena, California.

Signature: McKenzie Scott (May 5, 2026 10:16:32 PDT)

Email: mscott@cityofpasadena.net

McKenzie Scott

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

ERICA JIMENEZ, individually and on behalf of a class of similarly situated individuals,

Plaintiff,

v.

DR. ERICA PAN, in her official capacity as Director of the California Department of Public Health; DR. BARBARA FERRER, in her official capacity as Director of the Los Angeles County Department of Public Health; MANUEL CARMONA, in his official capacity as the Director of Public Health for the Pasadena Public Health Department; LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH; and PASADENA PUBLIC HEALTH DEPARTMENT,

Defendants.

Case No. 2:26-cv-03500

[PROPOSED] ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION [ECF NO. 13]

On May 4, 2026, Plaintiff filed a Motion for Preliminary Injunction (Motion) requesting that the Court enjoin Defendants from implementing the racial eligibility criterion of the Black Infant Health (BIH) program, and for Defendants to permit her to apply and participate in the BIH program before she reaches six months postpartum and is thereby ineligible for services under that program.

The Court, having considered Plaintiff's Motion, hereby DENIES the Motion and ORDERS as follows:

1. Plaintiff shall not be entitled to the injunctive relief she seeks.
2. Defendants may continue to implement the BIH program in its current form, without altering or modifying the program.

IT IS SO ORDERED.

Dated:

HON. SHERILYN PEACE GARNETT
UNITED STATES DISTRICT JUDGE

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Attorneys for Defendants, MANUEL CARMONA, in his official capacity as the Director of Public Health for the Pasadena Public Health Department and PASADENA PUBLIC HEALTH DEPARTMENT

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

ERICA JIMENEZ, individually and on behalf of a class of similarly situated individuals,

Plaintiff,

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DR. ERICA PAN, in her official capacity as Director of the California Department of Public Health; DR. BARBARA FERRER, in her official capacity as Director of the Los Angeles County Department of Public Health; MANUEL CARMONA, in his official capacity as the Director of Public Health for the Pasadena Public Health Department; LOS ANGELES COUNTY DEPARTMENT OF PUBLIC HEALTH; and PASADENA PUBLIC HEALTH DEPARTMENT,

Defendants.

Case No. 2:26-cv-03500-SPG-SP

Assigned to Hon. Sherilyn Peace Garnett

NOTICE OF JOINDER BY DEFENDANTS MANUEL CARMONA AND PASADENA PUBLIC HEALTH DEPARTMENT TO DEFENDANT DR. ERICA PAN'S OPPOSITION TO PLAINTIFF ERICA JIMENEZ' MOTION FOR PRELIMINARY INJUNCTION

Hearing Date: May 27, 2026
Time: 1:30 PM
Ctrm: 5C

Complaint filed: April 2, 2026
Trial date: None

TO THE HONORABLE COURT, ALL PARTIES, AND TO THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that Defendants Manuel Carmona and the Pasadena Department of Public Health (collectively, the "Pasadena Defendants") hereby join in Defendant Dr. Erica Pan's Opposition (Dkt. No. 26) to Plaintiff Erica Jimenez' Request for Preliminary Injunction (Dkt. No. 13).

Dated: May 6, 2026

MICHELE BEAL BAGNERIS
City Attorney
ARNOLD F. LEE
Chief Assistant City Attorney
AMANDA CUSICK
Assistant City Attorney

By: /s/ Arnold F. Lee
ARNOLD F. LEE
Chief Assistant City Attorney
Attorneys for Defendants,
MANUEL CARMONA, in his official capacity as the Director of Public Health for the Pasadena Public Health Department and PASADENA PUBLIC HEALTH DEPARTMENT